



mapleleaf-school.com

Alyce Heights Drive, Alyce Glen, Petit Valley, Trinidad, W.I.
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MEDICAL INFORMATION

CONTACT INFORMATION

Student Surname	First Name	Date of Birth	
Home Address	City	Home Telephone	
Mother/Guardian Surname	First Name	Cell Phone	Work Phone
Father/Guardian Surname	First Name	Cell Phone	Work Phone
Family Doctor Name	Address		Work Phone
OTHER CONTACTS (who may be asked to pick up your child if you are unavailable)			
Babysitter Name	Address	Cell Phone	
Neighbour Name	Address	Cell Phone	
Nearby Relative Name	Address	Cell Phone	

HEALTH INFORMATION

Does your child have a health concern that we should be aware of? Y N If yes, please explain: _____

OTHER	DETAILS AND TREATMENT RESPONSE
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Seizures/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Vision: Glasses	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Contacts	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Hearing concerns	<input type="checkbox"/> Y <input type="checkbox"/> N _____

EMERGENCY AUTHORIZATION

In case of emergency every effort will be made to notify parents or guardians before transporting the child for treatment. In the event that the school is unable to contact a parent/guardian, please sign the following authorization so we may take the necessary action.

I authorize **Maple Leaf International School** to send or take _____ for emergency treatment to:

St. Clair Medical Centre, St. Clair Y N _____

West Shore Medical Y N _____

Other Y N _____

We also agree to reimburse Maple Leaf International School for any or all medical expenses incurred.

Signature of Parent/Guardian

Print Name

Dated